Washington State Department of Health

Please fax completed forms to Communicable Disease Epidemiology at 206-418-5515.

Supplemental Form for Pregnant/Postpartum Women Hospitalized or Death from Influenza

County

PATIENT INFORMATION

Name (last, first) _____

Birth date ___/___/___ **Age** _____

CLINICAL INFORMATION

Y N DK NA

☐ ☐ ☐ ☐ **Pregnant at disease onset**

Estimated delivery date: ___/___/___

Y N DK NA

☐ ☐ ☐ ☐ **Postpartum (up to 8 weeks after delivery)**

Y N DK NA

☐ ☐ ☐ ☐ **Hospitalized**

Hospital Name:_____

Admit date ___/___/___

Discharge date ___/___/___

Y N DK NA

☐ ☐ ☐ ☐ **Transferred to other hospital**

Hospital Name:_____

Admit date ___/___/__

Discharge date ___/___/__

Pregnancy Outcome:

- ☐ **Still pregnant/undelivered**
- ☐ **Spontaneous abortion**
- ☐ **Therapeutic abortion**
- ☐ **Ectopic**
- ☐ **Fetal Death**
- ☐ **Live Birth**

FOR LIVE BIRTH OR FETAL DEATH ONLY:

Delivery Date: ___/___/___

Gestational Age:_____**(weeks)**

Type of delivery:

- ☐ **Vaginal delivery**
- ☐ **Cesarean**

Y N DK NA

☐ ☐ ☐ ☐ **Trial of Labor**

☐ ☐ ☐ ☐ **Fever in Labor or Delivery, or w/i 48 hours**

Predisposing Conditions

Y N DK NA

☐ ☐ ☐ ☐ Diabetes/Gestational Diabetes

☐ ☐ ☐ ☐ Pre-eclampsia/Pregnancy Hypertension

INFANT CLINICAL INFORMATION IF LIVE BIRTH

Name (last, first)_____

Birth weight in grams: _____

Apgar scores: _____ 5 minute

Y N DK NA

☐ ☐ ☐ ☐ Discharged live

☐ ☐ ☐ ☐ Transferred Hospital Name:_____ Discharge date: ___/___/___

☐ ☐ ☐ ☐ Died Death date ___/___/__

NOTES

MCH Investigator _____ Record complete date ___/___/___

Local contact:_____ Contact Phone: